Message

From: bounce-34786371-62701352@listserv.unc.edu [bounce-34786371-62701352@listserv.unc.edu]
on behalf of Occupational & Environmental Medicine for Clinicians & Public Health Professionals digest [occ-env-med-l@listserv.unc.edu]
Sent: 6/19/2014 4:19:23 AM
To: occ-env-med-l digest recipients [occ-env-med-l@listserv.unc.edu]
Subject: occ-env-med-l digest: June 18, 2014

OCC-ENV-MED-L Digest for Wednesday, June 18, 2014.

1. IARC meta-analysis links Glyphosate exposure & non-Hodgkin lymphoma
2. DOT question
3. Re: DOT question
4. Glyphosate and NHL
5. Aggravation of an old injury vs. New Injury

Subject: IARC meta-analysis links Glyphosate exposure & non-Hodgkin lymphoma
From: Rebecca Cohen <rcohen18@jhu.edu>
Date: Wed, 18 Jun 2014 09:19:08 -0400
X-Message-Number: 1

FYI/RC

Scientists at the International Agency for Research on Cancer have found
what appears to be a strong link between pesticide exposure and a blood
cancer called non-Hodgkin lymphoma.
...
The U.S. Department of Agriculture recently reported
<http://www.nass.usda.gov/Surveys/Guide_to_NASS_Surveys/Ag_Resource_Management/ARMS_Soybeans_Factsheet/ARMS_2012_Soybeans.pdf>
that
herbicide use doubledâ€" from 62 million pounds in 1996 to 128 million pounds
in 2012. Glyphosate [inc. "Roundup"/ Monsanto] now represents more than 83
percent of the chemical pesticides used in the U.S. annually.
...

http://www.ewg.org/agmag/2014/05/study-glyphosate-doubles-risk-lymphoma

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Non-Hodgkin lymphoma and occupational exposure to agricultural pesticide
chemical groups and active ingredients: a systematic review and
meta-analysis <http://www.ncbi.nlm.nih.gov/pubmed/24762670?&report=abstract>

Schinasi L., Leon M.E.
Int J Environ Res Public Health; 2014; 11(4): 4449-4527

PMID:24762670

Abstract as provided by PubMed

This paper describes results from a systematic review and a series of
meta-analyses of nearly three decades worth of epidemiologic research on
the relationship between non-Hodgkin lymphoma (NHL) and occupational
exposure to agricultural pesticide active ingredients and chemical groups.
Estimates of associations of NHL with 21 pesticide chemical groups and 80
active ingredients were extracted from 44 papers, all of which reported
results from analyses of studies conducted in high-income countries. Random
effects meta-analyses showed that phenoxy herbicides, carbamate
insecticides, organophosphorus insecticides and the active ingredient
lindane, an organochlorine insecticide, were positively associated with
NHL. In a handful of papers, associations between pesticides and NHL
subtypes were reported; B cell lymphoma was positively associated with
phenoxy herbicides and the organophosphorus herbicide glyphosate. Diffuse
large B-cell lymphoma was positively associated with phenoxy herbicide
exposure. Despite compelling evidence that NHL is associated with certain
chemicals, this review indicates the need for investigations of a larger
variety of pesticides in more geographic areas, especially in low- and

middle-income countries, which, despite producing a large portion of the world's agriculture, were missing in the literature that were reviewed

http://www.iarc.fr/en/publications/scientific-papers/index.php?Author=&TextOptionAuthor=0&Title=&TextOptionTitle=0&Keywords=+glyphosate&TextOptionKeywords=0&StartYear=&EndYear=&Limit=25&Sort=0&ShowAbstract=on&MatchAllCriteria=on&CaseSensitive=&SearchButton=Search

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Subject: DOT question
From: "Verlin K. Janzen" <JanzenV@hutchclinic.com>
Date: Wed, 18 Jun 2014 09:28:52 -0500
X-Message-Number: 2

Are there any times a driver would need a Medical Certificate - but not need a CDL? If so, when?

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[cid:image001.png@01CF8AD7.B798CD40]<http://www.hutchclinic.com/>

Subject: Re: DOT question
From: Natalie Hartenbaum <natah@comcast.net>
Date: Wed, 18 Jun 2014 10:44:42 -0400
X-Message-Number: 3

MANY!!!!!

To start the definition of CMV differ for the Medical certificate - in brief, GVR of 10,001 pounds or greater (along with other criteria) and the CDL (required by Feds at 26,001 or more pounds as one of the criteria although states may have different criteria).

This should have been covered in any NRCME training.

Reviewed in detail in a recent issue of CDME Review.

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On Jun 18, 2014, at 10:28 AM, Verlin K. Janzen <JanzenV@hutchclinic.com> wrote:

> Are there any times a driver would need a Medical Certificate - but not need a CDL? If so, when?
>
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Subject: Glyphosate and NHL
From: "GOLDSTEIN, DANIEL A [AG/1000]" <daniel.a.goldstein@monsanto.com>
Date: Wed, 18 Jun 2014 16:01:18 +0000
X-Message-Number: 4

Please see below regarding the report of an association of glyphosate with NHL.

Please ALSO NOTE that I am a full time employee of the Monsanto Company, leading producer of Glyphosate products and glyphosate tolerant crops. It is obvious in my signature line and e-mail- but in the interest of full transparency and in alignment with the communications guidelines for the listserve I highlight it here. The general comments are intended for a lay audience and are simplified accordingly, but you will find detailed technical comments with references below.

General Comments
Schinasi and Leon performed a meta-analysis of 44 studies on the relationship between non-Hodgkin lymphoma (NHL) and occupational exposure to 80 agricultural pesticide active ingredients. The study claims that glyphosate exposure was positively associated with NHL, and particularly B cell lymphoma. This claim is not substantiated by the information put forth in this paper or the extensive body of literature demonstrating that glyphosate does not cause cancer, including NHL. Experimental evidence from multiple long-term studies with laboratory animals demonstrates that glyphosate is not mutagenic or carcinogenic. Based on this and the points below, the biological plausibility of the glyphosate / NHL finding is doubtful.

· Glyphosate's overall low toxicity and its excellent safety profile are major benefits which have contributed to the widespread use of glyphosate-based plant protection products.

· Glyphosate has been thoroughly evaluated by regulatory agencies around the globe and all agree that the available data do not show glyphosate to be either carcinogenic or mutagenic.

· Several scientific reviews of available epidemiological studies conclude that there are no positive associations between glyphosate and cancer

· Available exposure data for glyphosate demonstrate a very large margin of exposure (safety margin between human exposure and doses causing effects in animals). This fact, combined with the lack of evidence for genotoxicity, must be considered when assessing biological plausibility.

· The Agricultural Health Study represents the largest epidemiological study for pesticide exposures and no association for glyphosate and NHL was found.

· Several of the studies used by Schinasi et al. to evaluate the association between glyphosate and NHL either found no positive association, no significant association, or suffered from numerous flaws in design or interpretation of the data.

· While the meta-analysis may support the hypothesis that pesticides are associated with NHL; the studies used in the current analysis lack sufficient information on pesticide exposure and toxicological evidence to support a causal relationship.

· A potential source of error in any meta-analysis is publication bias, characterized as undue influence by smaller studies included in the meta-analysis, and the resulting bias may invalidate the conclusions. While it is reasonable to believe that this meta-analysis suffers from publication bias, no efforts were made by Schinasi et al. to assess the potential publication bias in this meta-analysis.

Technical Comments
Regulatory authorities and independent experts around the world agree that glyphosate, the active ingredient in Roundup® brand herbicides, does not cause cancer, even at very high doses. Glyphosate is one of the most widely used and most comprehensively evaluated active ingredients in herbicides worldwide and all regulatory assessments consistently concluded that glyphosate does not pose any unacceptable risk to human health, the environment, or non-target animals and plants. Glyphosate's overall low toxicity and its excellent safety profile are major benefits which have contributed to the widespread use of glyphosate based plant protection products.

Glyphosate has been thoroughly evaluated (Click here <http://www.monsanto.com/products/documents/glyphosate-background-materials/gly_cancer_bkg.pdf> for a more information) for environmental and human safety by the Environmental Protection Agency (EPA 1993<http://www.epa.gov/oppsrrd1/REDs/factsheets/0178fact.pdf>) and several other health organizations (WHO, 1994<http://www.inchem.org/documents/ehc/ehc/ehc159.htm>; WHO/FAO, 2004<http://www.fao.org/agriculture/crops/agp-home/en/>; European Commission, 2002<http://ec.europa.eu/food/plant/protection/evaluation/existactive/list1_glyphosate_en.pdf>). Additionally, the BfR (Federal Institute for Risk Assessment or Bundesinstitut für Risikobewertung) has finalized its report for the re-evaluation<http://www.bfr.bund.de/en/the_bfr_has_finalised_its_draft_report_for_the_re_evaluation_of_glyphosate-188632.html> of glyphosate. The agency reviewed all available toxicological studies (nearly 300) including 150 new studies representing a subset of nearly 900 publications considered. As a result, the BfR concluded "[for] the active substance glyphosate [the] available data do not show carcinogenic or mutagenic properties of glyphosate nor that glyphosate is toxic to fertility, reproduction or embryonal/fetal development in laboratory animals."

Recently, several reviews have summarized the epidemiological studies on glyphosate and humans: Mink et al., 2011<http://www.ncbi.nlm.nih.gov/pubmed/21798302>, Mink et al., 2012<http://www.ncbi.nlm.nih.gov/pubmed/22683395>, and Williams et al., 2012<http://www.ncbi.nlm.nih.gov/pubmed/22202229>. Specifically, Mink et al., 2012 looked at epidemiologic studies of glyphosate and cancer and "found no consistent pattern of positive associations indicating a causal relationship between total cancer (in adults or children) or any site-specific cancer and exposure to glyphosate."
Glyphosate and Non-Hodgkin's Lymphoma
The authors cite "striking increases" in the incidence of NHL over the last 30 years and "interest in identifying environmental and occupational exposures associated with this cancer has accompanied this trend" as an impetus for the current study. In fact, "while the incidence of NHL increased in most developed countries through 1990 it has leveled off in recent years" (pg 34, American Cancer Society, Global Cancer Facts & Figures<http://www.cancer.org/acs/groups/content/@epidemiologysurveilance/documents/document/acspc-027766.pdf>). This presumption is also not supported by the references cited by Schinasi and Leon. For example, Eltom et al., 2002, evaluated the incidence of Kaposi's sarcoma and NHL between 1973 and 1998 in relation to the AIDS epidemic (HIV is a leading risk factor). While the incidence for both cancers rose in conjunction with the AIDS epidemic starting around 1981 and continued to the early 1990's, they fell sharply as infection rates slowed and effective antiretroviral therapies were introduced. Adamson et al., 2007, reported the registration rates for NHL and Hodgkin's lymphoma in Europe through 2006 and concluded that "[i]n recent history [...] there is a suggestion that the rate of increase is less and stable."

Most of the known risk factors for NHL are associated with individuals with an altered immune function. For example, those receiving immune suppressants (e.g., transplant patients) or people with severe autoimmune conditions (e.g., AIDS patients or HIV infection). In fact, NHL risk is about 11 times higher in individuals with AIDS (Seaberg EC et al., 2010<http://www.ncbi.nlm.nih.gov/pubmed/20672354>).

A number of epidemiological studies focused on pesticide exposure and health outcomes. Before discussing these, it is important to provide some perspective on what is meant by "exposure" to glyphosate in these epidemiological studies. This is because when evaluating epidemiologic findings the range of likely exposure levels to the exposure levels of toxicologic significance should be compared (Acquavella et al. 2003<http://www.ncbi.nlm.nih.gov/pubmed/12547479>). Based on available data, the level of exposure to farmers and their families is predicted to be very low and suggest levels that are well below the Allowable Daily Intakes (ADIs) for glyphosate. This statement is based on available exposure data from exposure studies. One of the most comprehensive is the Farm Family Exposure Study (FFES) conducted by investigators at the University of Minnesota (Acquavella et al., 2004,<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1241861/>). The study monitored farm families, including spouses and children. Urine samples were collected the day before glyphosate was to be applied, the day of application and for three days after application. Forty percent of the 48 farmers who applied glyphosate had no detectable levels of glyphosate in their urine on the day of application. The detection method was capable of detecting 1 part per billion (ppb) glyphosate. The average urine concentration for the farmers was 3 ppb.

In fact, the maximum systemic dose resulting from application of glyphosate was 0.004 mg/kg. The cancer no-effect levels for glyphosate, based on rat and mouse lifetime feeding studies, are 1,000 and 1,500 mg/kg/day, respectively (Williams et al. 2000<http://www.sciencedirect.com/science/article/pii/S0273230099913715>). Accordingly, if a similar application was made every day for a lifetime, the systemic dose would be at least 250,000-fold lower than the cancer no-effect level in rodents. This is important to note as this represents a very large margin of exposure and this, combined with the lack of evidence for genotoxicity outlined above, must be considered when assessing biological plausibility.

In a separate study, the Friends of the Earth / BUND<http://www.bfr.bund.de/cm/349/glyphosate-in-urine-concentrations-are-far-below-the-range-indicating-a-potential-health-hazard.pdf> analyzed 182 urine samples looking for the presence of glyphosate. The German regulatory agency, the Federal Institute for Risk Assessment<http://www.bfr.bund.de/cm/349/glyphosate-in-urine-concentrations-are-far-below-the-range-indicating-a-potential-health-hazard.pdf>, concluded that "[t]he BUND study results are plausible and indicate a background contamination of glyphosate; however far below a level which poses a potential health risk." In fact, regulatory authorities in Europe (EU) and elsewhere have conducted numerous independent health assessments and consistently conclude that glyphosate does not pose any unacceptable risk to human health or the environment.

· Low levels of residues of glyphosate are permitted in food and are considered safe. It is not surprising to find glyphosate in urine should a person ingest food with residues of glyphosate. The occurrence of residue in food does not indicate potential harm. Glyphosate is not metabolized by the human body but is eliminated in the urine and feces.

· The mere presence of a compound does not equate with harm or a hazard risk. Importantly, even the highest value reported in the studies above suggests intakes well below the Allowable Daily Intake (1.75 mg/kg/day), a value that is considered an acceptable oral exposure every day throughout one's life without incurring any appreciable health risk.

· The U.S. EPA, other regulatory agencies around the world, and the World Health Organization have reviewed extensive data on the safety of glyphosate and have established intakes below which there is no reason for health concerns.
Of all the epidemiological studies performed, the largest (57,000 US farmers) is the Agricultural Health Study (AHS) (Alavanja MCR, Sandler D, McMaster S, Zahm S, McDonnell C, Lynch C, et al. 1996. The Agricultural Health Study. Environ Health Perspect 104:362-369.) Unlike Schinasi et al., an association between NHL and glyphosate was never reported within the AHS study itself. In fact, no association was reported with any type of cancer. This result is in line with the analysis put forth by Mink et al., 2012, which summarizes the relevant epidemiology cancer studies and concludes that no relationship between glyphosate and any cancer outcome exist within the considerable volume of published epidemiology data.
Numerous publications analyzed data from the AHS study and of these only De Roos et al., 2005<http://www.ncbi.nlm.nih.gov/pubmed/15626647>, (included in the meta-analysis performed by Schinasi et al) look at cancer incidence in association with glyphosate exposure. Importantly, De Roos et al. concluded that "there was no association between glyphosate exposure and all cancer incidence or most of the specific cancer subtypes we evaluated including NHL." They did find a potential association between multiple myeloma and glyphosate exposure but this finding has been refuted (Farmer et al., 2005<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1257613/>).
Of the 44 studies used in the meta-analysis by Schinasi et al, six specifically mention and association between NHL and glyphosate (De Roos et al., 2003<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1740618/>; De Roos et al., 2005<http://www.ncbi.nlm.nih.gov/pubmed/15626647>; Eriksson et al., 2008<http://www.ncbi.nlm.nih.gov/pubmed/18623080>; Hardell et al., 2002<http://www.ncbi.nlm.nih.gov/pubmed/12148884>; McDuffie et al., 2001<http://www.ncbi.nlm.nih.gov/pubmed/11700263>; Orsi et al., 2009<http://bvsalud.org/portal/resource/en/mdl-19017688>). Of these, Eriksson et al., 2008 also reports an association between B cell lymphoma and glyphosate.

De Roos et al., 2003; Hardell et al., 2002; and McDuffie et al., 2001 all report an increased risk of NHL following glyphosate exposure. It is important to note that, because these studies are retrospective in design, they are susceptible to recall bias when reporting exposure to glyphosate. De Roos et al. 2005, state recall bias, characterized as inaccurate recollections by study participants, as a reason for their discrepant finding regarding no association between glyphosate and NHL. Additionally, the epidemiological studies used for the meta-analysis performed by Schinasi et al. associating glyphosate and NHL lack any direct toxicological evidence. Furthermore, while the meta-analysis may support the hypothesis that pesticides are associated with NHL; the studies lack sufficient qualitative and quantitative information on pesticide exposure and other information on risk factors including the possible influence of other occupational, environmental, lifestyle, or genetic factors for hematopoietic cancers to identify specific causes. Finally, while it is reasonable to believe that this meta-analysis suffers from publication bias, characterized as undue influence by smaller studies included in the meta-analysis, no efforts were made by Schinasi et al. to assess the potential publication bias in this meta-analysis.

Eriksson et al., 2008 conducted a population-based case-control study of exposure to a variety of pesticides and NHL or several histopathological categories of NHL (e.g., B cell lymphoma). Remembering that odds ratios (OR) above 1 suggest an association but are not significant if the confidence intervals includes the null value of 1.0. Eriksson et al. report ORs for glyphosate exposure of <10 days and >10 days to be 1.69 (95% CI: 0.70-4.07) and 2.36 (1.04-5.37), respectively. The ORs for "latency" periods of 1-10 years and >10 years were 1.11 (95% CI: 0.24-5.08) and 2.26 (95% CI: 1.16-4.40), respectively. The odds ratios for the other types (total B-cell lymphomas, grade I-III follicular lymphoma, diffuse large B-cell lymphoma, other specified B-cell lymphoma, unspecified B-cell lymphoma, and T-cell lymphomas) were

above 1.0, but were not statistically significant. From this the authors concluded "glyphosate was associated with a statistically significant increased OR for lymphoma in our study..." However, the interpretation of the results of this study is hindered by potential problems including referral, selection, or recall (other information) biases, evidence for a causal relationships is based on a very weak association, and confounding factors such as exposure to other pesticides (Mink Review<http://portals.monsanto.com/enterprise/Conservatory/Library/Lists/Library/Attachments/19489/Mink%20Review%20of%20Eriksson%20et%20al%20%202008_RV030609.pdf>).

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Subject: Aggravation of an old injury vs. New Injury
From: Paul Ng <trinityfd0@gmail.com>
Date: Wed, 18 Jun 2014 15:10:02 -0500
X-Message-Number: 5

Thank you all for the input.
Here are the responses that I received. I also attached the CFR 1904.6 as suggested by one reply. For this case, I recoded as aggravation. I use a minimum of at least 12 month symptom free, limitation free after clinical resolution to determine a "new case" if the condition recurs (if it recurs within 12 mo, it is an aggravation). This is an arbitrary time frame and I will change if good evidence based studies suggest otherwise:

-Its aggrevation of pre existing injury FYI I'm an OSHA Institute Accred Instructor and AN RN with 40 years expert thus OSHA has always coded this type as aggrevation because of the type of Injury (employee needs to assigned to a different Job)

-Simply put I would classify this as an illness and not an injury at this point since there was not a specific injury/event and link as a reoccurrence.

-sounds like the task needs to be ergonomically assessed for ways to prevent this recurrent injury.

-If the patient became pain-free after treatment, it canâ€™t be *aggravation* (please look at the AMA guides for disability evaluation for exact definitions). â€œRecurrenceâ€ is probably true. From a coding perspective, I think that recurrent and new are not mutually exclusive. I would side with your PA.

-What are your state laws? I'm in Virginia where the only upper extremity disorder that may be compensable from repetitive work is Carpal Tunnel Syndrome and then only if a preponderance of the evidence indicates it is caused by their work.

We still see lateral epicondylitis from acute strains and contusions.

In this case; how long did the original injury last before apparent resolution? If it took a couple of months there likely was enough injury that there was a significant amount of scar tissue formation. It's been my understanding that stretching for 6 months after clinical resolution of lateral epicondylitis is important in order to prevent a "flare-up" of pain resulting from stretching the scar tissue. This occurs because scar tissue contracts over time, thus the importance of stretching. I have no double blinded prospective controlled studies to support this point but I've treated a lot of lateral epicondylitis over the past 40 years, generally with good success.

-For me, this would be aggravation of prior injury and I would have â€œre-openedâ€ the older claim. I donâ€™t know if there is a time limit for doing this, however (ie, must be re-opened within 1 year or 5 yearsâ€¦ perhaps it is different by state?). And I donâ€™t think it should be a new entry on the OSHA log. Just my two cents, could be wrong. Would appreciate a summary of the responses you get. Great questions.

-This kind of question is always a judgment call, depending on his clinical condition and the amount of time that elapsed from the previous injury to the current one. Had he been truly pain free since the last discharge, or was he taking an occasional NSAID for it, using ice or heat sometime or an elbow wrap? If any of these things apply, that would favor an aggravation of prior injury that hadnâ€™t totally resolved. If none of these apply, that favors a new injury. Regarding the time frame, was the 4 months from the initial injury or from the discharge from that injury? Four months from discharge is a little gray. If it had been 3 or weeks, Iâ€™d chalk it up to the original injury. If it had been 6 months, a year or more, that would tilt it toward being a new injury. If the 4 months was from the initial DOI, then the time from discharge must have been considerably less, as he probably had other modalities before the injections.

If he developed this condition from work, and then was put back to the same work and developed it again, then the employer needs to look at that job to see what can be modified, no matter how it is labeled for OSHA. At any rate, an occupational aggravation of a pre-existing condition (whether work related or not) is OSHA recordable. Thatâ€™s why so many employers are reluctant to take an employee back to work who had a non-work related injury; they donâ€™t want to convert it to workersâ€™ comp and OSHA recordable by aggravation of the condition from work.

I wouldnâ€™t be interested in helping the employer try to minimize this be calling it an aggravation of an old injury. Other people are probably at risk as well.

-Personally, it seems an exacerbation of a previous injury. I say that because:

1. It's justifiable as you've presented it, and

2. It keep the peace with the employer and it's good business, without compromising ethics.

-If he had returned to his previous pre-injury work status after release to full duty, OSHA would consider this a new injury. Per section 1904.6 if an exposure triggers a recurrence of symptoms, it must be considered a new case. Whereas if signs or symptoms occur where there is no exposure, it is not a new case. So if in this case the employee is exposed to a repetitive motion causing the symptom to recur, it should be considered a new case and is therefore recordable.

-Unless other employees doing the same/similar jobs are getting

"injured", I would consider it an aggravation (of the earlier injury +/- underlying predisposition).

-As an employer, I would question new versus aggravation of the original injury.

After local injection, isn't it fairly common for need for an additional local injection in 3 to 6 months. How did the PA determine that the client was fully recovered? I would also require that the local injection to the elbow was given by an orthopedist.

-My vote would be that this is not a new injury if the same spot hurts and

it is from the same repetitive motion that caused it in the first place. If the

elbow was all better from treatment and then the patient fell skiing or

whatever and injured that elbow I would call it a new injury. Perhaps

the patient needs to learn how to kinesiotape his arm so that his elbow fares

better on the job.

-I believe it was an aggravation also. I also believe that an injury case can be opened and reopened for up to 12 years after the event. I would think that would make it still the â€œfirstâ€ injury and not recorded as another â€œnewâ€ injury. This does benefit the company in that respect. They should really focus on the ergonomics going on at the job, however.

Regulations (Standards - 29 CFR) - Table of Contents
<https://www.osha.gov/pls/oshaweb/owasrch.search_form?p_doc_type=STANDARDS&p_toc_level=0&p_keyvalue=>

â€¢ Part Number:

1904

â€¢ Part Title:

Recording and Reporting Occupational Injuries and Illness

â€¢ Subpart:

C

â€¢ Subpart Title:

Recordkeeping Forms and Recording Criteria

â€¢ Standard Number:

1904.6
<https://www.osha.gov/pls/oshaweb/owalink.query_links?src_doc_type=STANDARDS&src_unique_file=1904_0006&src_anchor_name=1904.6>

â€¢ Title:

Determination of new cases.

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*1904.6(a)
<https://www.osha.gov/pls/oshaweb/owalink.query_links?src_doc_type=STANDARDS&src_unique_file=1904_0006&src_anchor_name=1904.6(a)>*

Basic requirement. You must consider an injury or illness to be a "new case" if:

1904.6(a)(1)

The employee has not previously experienced a recorded injury or illness of the same type that affects the same part of the body, or

1904.6(a)(2)

The employee previously experienced a recorded injury or illness of the same type that affected the same part of the body but had recovered completely (all signs and symptoms had disappeared) from the previous injury or illness and an event or exposure in the work environment caused the signs or symptoms to reappear.

1904.6(b)

Implementation.

1904.6(b)(1)

When an employee experiences the signs or symptoms of a chronic work-related illness, do I need to consider each recurrence of signs or symptoms to be a new case? No, for occupational illnesses where the signs or symptoms may recur or continue in the absence of an exposure in the workplace, the case must only be recorded once. Examples may include occupational cancer, asbestosis, byssinosis and silicosis.

1904.6(b)(2)

When an employee experiences the signs or symptoms of an injury or illness as a result of an event or exposure in the workplace, such as an episode of occupational asthma, must I treat the episode as a new case? Yes, because the episode or recurrence was caused by an event or exposure in the workplace, the incident must be treated as a new case.

*1904.6(b)(3)
<https://www.osha.gov/pls/oshaweb/owalink.query_links?src_doc_type=STANDARDS&src_unique_file=1904_0006&src_anchor_name=1904.6(b)(3)>*

May I rely on a physician or other licensed health care professional to determine whether a case is a new case or a recurrence of an old case? You are not required to seek the advice of a physician or other licensed health care professional. However, if you do seek such advice, you must follow the physician or other licensed health care professional's recommendation about

whether the case is a new case or a recurrence. If you receive recommendations from two or more physicians or other licensed health care professionals, you must make a decision as to which recommendation is the most authoritative (best documented, best reasoned, or most authoritative), and record the case based upon that recommendation.

END OF DIGEST
